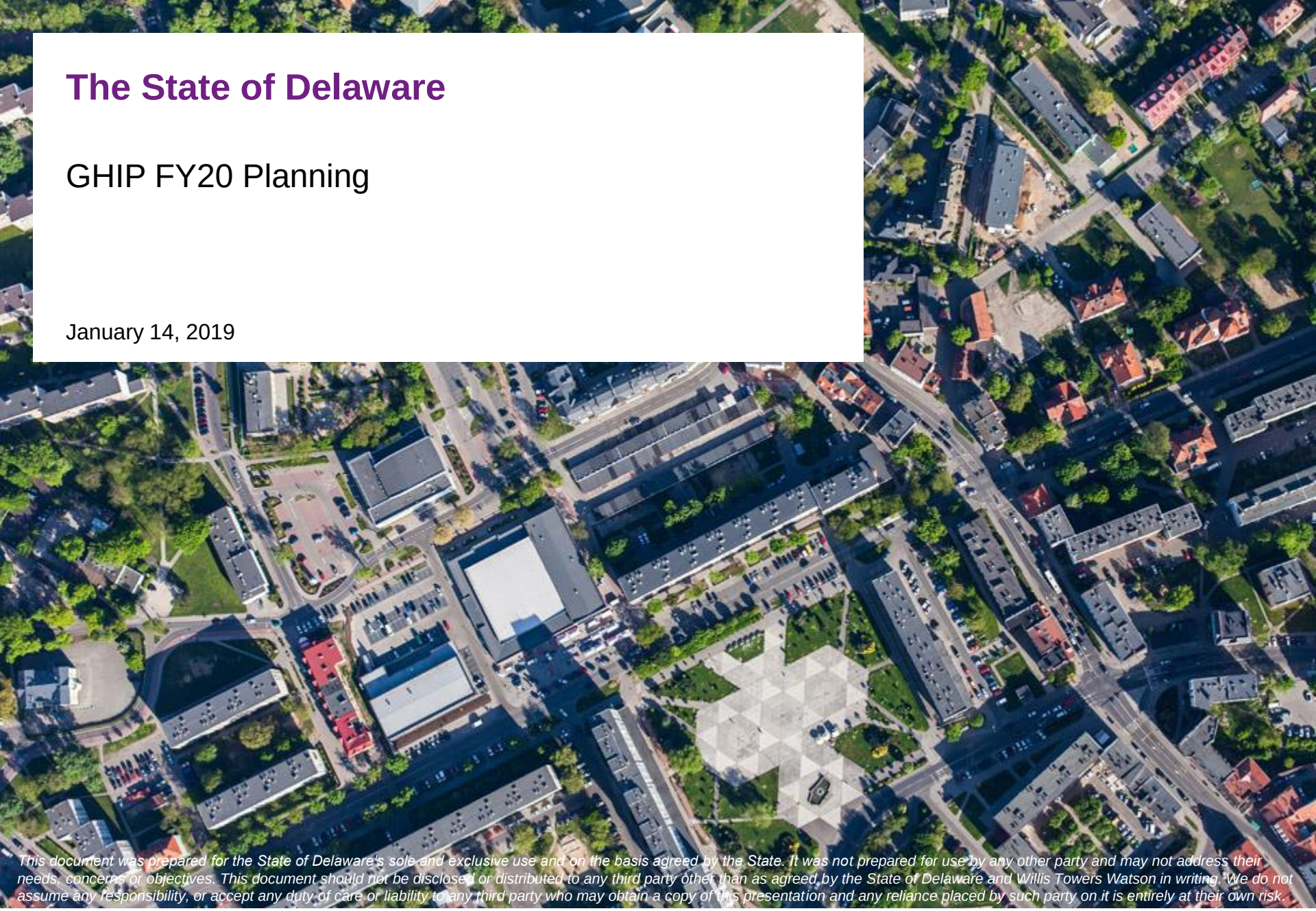
The State of Delaware

GHIP FY20 Planning

January 14, 2019



Willis Towers Watson

Contents

GHIP long term health care cost projections (FY19 Q1 update[1])

Illustrative: Increase premium rates by 2% annually starting in FY20; use full surplus available

FY20 reflects employee contribution increases of $0.53 – $5.47 per month ($6.36 – $65.64 per year) and State subsidy increases of $13.38 – $35.72 per employee per month ($160.56 – $428.64 per year) effective 7/1/2019

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[1,6]	FY21 Projected[6]	FY22 Projected[6]	FY23 Projected[6]
Average Enrolled Members	123,132	125,488	125,861	128,308	130,874	133,491	136,161
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$814.8	$831.1	$847.7	$864.7	$882.0
2.0% Annual Premium Increase Starting FY20	-	-	-	*$16.6*	*$33.9*	*$52.5*	*$72.2*
Other Revenues[3]	$81.6	$92.1	$88.6	$99.3	$106.3	$113.8	$121.9
Total Operating Revenues	**$880.6**	**$903.0**	**$903.5**	**$947.0**	**$987.8**	**$1,031.0**	**$1,076.1**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)	$816.8	$853.9	$921.6	$985.6	$1,055.6	$1,130.5	$1,210.8
% Change Per Member	*1.8%*	*2.6%*	*7.4%*	*4.9%*	*5.0%*	*5.0%*	*5.0%*
Excise Tax Liability[4]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($18.1)**	**($38.6)**	**($67.7)**	**($108.6)**	**($151.0)**
Balance Forward	$38.9	$102.7	$151.8	$133.7	$95.1	$27.4	($81.2)
Ending Balance	$102.7	$151.8	$133.7	$95.1	$27.4	($81.2)	($232.2)
- Less Claims Liability[5]	*$54.0*	*$58.9*	*$61.3*	*$65.6*	*$70.3*	*$75.3*	*$80.6*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$24.3*	*$26.0*	*$27.8*	*$29.8*	*$31.9*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$48.1**	**$3.5**	**($70.7)**	**($186.3)**	**($344.7)**

Note: FY17 actual based on final June 2017 Fund Equity report; FY18 actual based on final June 2018 Fund Equity report; projected operating expenses based on experience through FY19 Q1; FY19 enrollment as of September 2018; reflects ESI FY17 Q4 restated claims; numbers in table may not add up due to rounding

[1] Includes approved design changes for site-of-care steerage for imaging/outpatient lab and COE services and proposed design changes for $0 statin coverage and preventive 3D mammography effective 7/1/2018 and implementation of SurgeryPlus COE effective 7/1/2019; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection); assumes no additional program changes in FY20 and beyond.

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23.

[3] Includes Rx rebates, EGWP payments, other revenues; includes fees for participating non-State groups (assumed to increase proportionally with membership growth and health care trend)

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022. Threshold assumed to increase at 2% annually

[5] FY19 Claims Liability and FY19 Minimum Reserve levels updated with data through June 2018; future years assumed to increase with overall GHIP expense growth

[6] FY20-FY23 projections based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives); assumes no additional program changes in FY20; assumes 2% annual growth in GHIP membership.

FY20 monthly rates and employee/retiree contributions

Illustrative: 2% increase effective 7/1/2019

FY20 reflects employee contribution increases of $0.53 – $5.47 per month ($6.36 – $65.64 per year) and State subsidy increases of $13.38 – $35.72 per employee per month ($160.56 – $428.64 per year) effective 7/1/2019

	FY 2019			FY 2020 with 2% Increase			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$709.27	$28.37	$680.90	$0.53	$6.36	$13.38	$160.56
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,467.45	$58.70	$1,408.75	$1.18	$14.16	$27.59	$331.08
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,078.16	$43.13	$1,035.03	$0.87	$10.44	$20.27	$243.24
Family	$1,798.42	$71.92	$1,726.50	$1,834.39	$73.37	$1,761.02	$1.45	$17.40	$34.52	$414.24
CDH Gold										
Employee	$719.68	$35.98	$683.70	$734.07	$36.70	$697.37	$0.72	$8.64	$13.67	$164.04
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,522.06	$76.10	$1,445.96	$1.52	$18.24	$28.32	$339.84
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,121.55	$56.07	$1,065.48	$1.11	$13.32	$20.88	$250.56
Family	$1,895.74	$94.78	$1,800.96	$1,933.65	$96.68	$1,836.97	$1.90	$22.80	$36.01	$432.12
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$740.46	$48.13	$692.33	$0.97	$11.64	$13.55	$162.60
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,561.19	$101.48	$1,459.71	$1.98	$23.76	$28.63	$343.56
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,132.73	$73.62	$1,059.11	$1.44	$17.28	$20.77	$249.24
Family	$1,909.82	$124.12	$1,785.70	$1,948.02	$126.63	$1,821.39	$2.51	$30.12	$35.69	$428.28
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$809.74	$107.29	$702.45	$2.11	$25.32	$13.77	$165.24
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,680.29	$222.64	$1,457.65	$4.38	$52.56	$28.57	$342.84
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,247.93	$165.35	$1,082.58	$3.27	$39.24	$21.20	$254.40
Family	$2,059.40	$272.86	$1,786.54	$2,100.59	$278.33	$1,822.26	$5.47	$65.64	$35.72	$428.64

FY20 planning

Subcommittee work

- Over the last several months, the Health Policy & Planning and Financial subcommittees met to discuss GHIP program and financial strategy, with a focus on changes and opportunities for FY20
- Several opportunities were reviewed with the Health Policy & Planning subcommittee, including:
  - Site-of-care steerage
  - Health management point solutions to address targeted health conditions
  - Centers of excellence
  - Other plan design changes
- Options that resonated with the subcommittee included site-of-care steerage changes and a particular health management point solution; these are presented in more detail on the following pages
- The subcommittee will continue to explore broader adoption of centers of excellence for the GHIP population, including consideration of plan design changes and incentives
  - Recommendations from SurgeryPlus will be presented at a future subcommittee meeting once the vendor completes its analysis of Delaware claims data from the Health Care Database
- In parallel, the Financial subcommittee evaluated the parameters for managing the financials of the GHIP, including process for setting fund reserves and using available surplus to offset future year plan expenses
- Both subcommittees developed recommendations for vote by the SEBC as outlined on the following pages

Subcommittee recommended site-of-care steerage options effective 7/1/19 (12/18/2018 meeting)

FY20 opportunities

Site-of-care steerage

- Aetna and Highmark were asked to assist with estimating the cost impact of the following plan design options for FY20
  - Impact of each type of service was modeled (details in Appendix)
  - Each option was modeled as if it were a standalone change – e.g., modeling for "Option 1" changes to outpatient lab copay does not include cost avoidance for "Option 1" changes to emergency room copay
- Both vendors were also asked to provide their recommendations for these plan design changes (details in Appendix)

Service *For PPO and HMO plans only*	FY19 Current	FY20 Design Options			Range of Cost Avoidance Opportunity
		Option 1	Option 2	Option 3	
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $40 copay	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $50 copay	$0.8m – $1.7m annual claim savings ($0.5m – $1.1m to General Fund)
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $60 copay	▪ $0 copay ▪ $65 copay	▪ $0 copay ▪ $75 copay	
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $30 copay	▪ $10 copay ▪ $40 copay	▪ $10 copay ▪ $50 copay	$1.6m – $2.6m annual claim savings ($1.1m – $1.7m to General Fund)
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $175 copay	▪ $15/$20 copay ▪ $200 copay		$1.4m – $2.6m annual claim savings ($0.9m – $1.7m to General Fund)
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)			De minimus cost impact to the State

FY20 opportunities

Infusion therapy site-of-care steerage

Subcommittee recommends implementing Highmark infusion therapy steerage program effective 7/1/19 (12/18/2018 meeting)

Infusion therapy defined:

- Intravenous administration of certain medications that treat conditions such as autoimmune disorders, enzyme replacement and rare/esoteric diseases
- Administered under the supervision of a medical professional
- Several possible sites of care: outpatient hospital facility, infusion center, doctor's office, or patient's home

Advantages to administering outside of a hospital: *significantly reduced cost of drug administration, reduced risk of patient exposure to hospital-acquired illnesses, enhanced privacy and comfort, potentially reduced travel time and associated expenses*

Aetna capabilities – *In place today*

- Site-of-care steerage program is currently in place for the State
- Drugs are segmented into two categories: Mandatory and Voluntary (based on clinical rule)
- Requires member's doctor to request prior authorization for infusion therapy from Aetna
- Aetna reviews request for medical necessity and clinical appropriateness
- Aetna will reach out to doctor to suggest alternative site of care if appropriate

Highmark capabilities – *Not in place today*

- Site-of-care steerage program is available for self-funded plan sponsors
- Also managed by a prior authorization initiated by the member's doctor, and includes review for medical necessity and clinical appropriateness
- Authorization will be denied if medical documentation submitted by doctor is insufficient to justify requested site-of-care or use of infusion
- Includes resubmission and appeal processes to address denied requests for prior authorization
- Includes assistance for members currently in treatment with a targeted drug; Customer Care Advocate will help member find alternative sites of care if member wishes to do so
- Does not apply to Medicfill plan

Estimated annual claim savings potential* for adding Highmark program: *$2.0m in FY20*

*Note: Reflects savings potential; actual savings are not guaranteed and should not be relied upon for budgeting purposes. Based on most recent incurred data (August 2017 – July 2018) for targeted drugs delivered in a hospital setting; reflects 67 members with 388 claims for 10 targeted drugs.

Subcommittee recommends implementing Livongo through Aetna, Highmark, and ESI effective 7/1/19 (12/18/2018 meeting)

FY20 opportunities

Diabetes prevention services

- The Health Policy & Planning subcommittee recommends implementing Livongo through Aetna and Highmark (for active employees and non-Medicare retirees) and Express Scripts (for Medicare retirees) for diabetes prevention services
  - Remote monitoring program that includes Livongo meter, unlimited testing supplies and 24/7/365 personalized support and coaching
  - Serves diabetic population- types 1 and 2
  - Non-Medicare and Medicare members
  - Eligible members identified through claims
  - 60 day implementation period, assigned Livongo implementation lead, “recruit” potential members through claims, provide communications through mail and email
  - Client reporting package includes executive summary, metrics, dashboards and various reports (member satisfaction, member engagement and clinical outcomes)
- Livongo member experience:
  - No out-of-pocket costs
  - Cellular meter connects directly to Livongo cloud
  - Real-time (within 3 minutes) outreach driven by dangerous readings
  - Coaching by Livongo Certified Diabetes Educators
  - Outreaches provided by phone, text and email

★ ***Estimated annual claim savings potential for adding Livongo program*** : $720k in FY20

Policy subcommittee recommendations for FY20 changes

- Implement the following changes for FY20:

Service *For PPO and HMO plans only*	FY19 Current	FY20 Proposed Change
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	 ▪ $0 copay ▪ $35 copay	 ▪ $0 copay ▪ $50 copay
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	 ▪ $0 copay ▪ $50 copay	 ▪ $0 copay ▪ $75 copay
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	 ▪ $10 copay ▪ $20 copay	 ▪ $10 copay ▪ $50 copay
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	 ▪ $15/$20 copay ▪ $150 copay	 ▪ $15/$20 copay ▪ $200copay
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)

Combined annual claim cost avoidance opportunity: $6.9m ($4.6m to General Fund)

- Implement Highmark's infusion therapy site-of-care steerage program ($2.0m claim savings potential, $1.3m to General Fund)
- Implement Livongo through Aetna, Highmark and Express Scripts ($720k claim savings potential, $500k to General Fund)
- ***Total annual claim cost avoidance opportunity: $9.6m ($6.4m to General Fund)***

GHIP claim liability and reserve methodology

Subcommittee recommends maintaining current methodology (12/18/2018 meeting)

Alternatives for consideration (details in Appendix)

- Financial Subcommittee reviewed current methodology for setting the claim liability

Methodology	Description	FY19 Claim Liability
Current	Estimated incurred but not paid ("IBNP") liability based on Aetna, Highmark, and ESI lag factors	$61.3M

- Financial Subcommittee also reviewed alternative methodologies for setting the minimum reserve level for GHIP

Methodology	Description	FY19 Reserve
★ **Current**	Upper bound of 97% confidence for WTW claim variability tool	$24.3M
Alternative 1	Upper bound of 98.5% confidence for WTW claim variability tool	$27.1M
Alternative 2	Upper bound of 98.5% confidence for WTW claim variability tool ***plus*** 1% load for potential population health risk volatility	$35.1M

- Continue to review claim liability on a quarterly basis and minimum reserve on an annual basis

Subcommittee recommends smoothing available surplus over 2 years (12/18/2018 meeting)

GHIP surplus modeling

Scenarios for consideration

- Using surplus to minimize annual premium increases may put a strain on future revenues needed to keep pace with health care cost trend
- GHIP surplus projected to be $48.1M by the end of FY19, based on assumptions outlined on page 2
- Financial Subcommittee discussed spreading the FY19 surplus level ($48.1M) over multiple years, rather than using the full amount to offset costs in FY20
  - Each scenario reviewed included a corresponding premium contribution increase to "balance" the fund ($0 surplus) by FY21 or FY22
  - Avoid the need for a more significant increase in a future year, which could be further exacerbated in a year of poor claims experience
- The following scenarios were considered:
  - ★ Spread $48.1M surplus over 2 years (use $24.0M surplus in FY20 by increasing premiums 4.5%* effective 7/1/2019)
  - Spread $48.1M surplus over 3 years (use $16.0M surplus in FY20 by increasing premiums 5.4%* effective 7/1/2019)
- Recommendation intended to address both current fund surplus, and available surplus in future years – Subcommittee may choose to revisit smoothing duration in the future

* Required premium increase assuming no program changes for FY20; if SEBC approves recommended FY20 program changes yielding $9.6M in savings, required premium increases drop to 3.2% (2 year smoothing) and 4.2% (3 year smoothing)

Financial subcommittee recommendations for FY20

- No change to claim liability or minimum reserve methodologies
  - FY20 projected claim liability: $64.9M; to be refreshed early 2019 based on updated lag factor analysis
  - FY20 projected minimum reserve: $25.7M
- Spread FY19 surplus over two years
  - Use $24M in surplus in FY20 and remaining $24M surplus in FY21
  - Revisit surplus smoothing methodology annually
- Health Policy & Planning Subcommittee recommendations for FY20 yield estimated $9.6M in claim cost avoidance – based on the most recent financial projections assuming 5% trend and recommended FY20 program changes, FY20 premiums will need to increase by **3.2% effective 7/1/2019**

Bringing it together: GHIP long term health care cost projections[1]

Subcommittee recommendations including FY20 program changes and smoothing surplus over 2 years

FY20 reflects employee contribution increases of $0.89 – $8.73 per month ($10.68 – $104.76 per year) and State subsidy increases of $21.36 – $57.17 per employee per month ($256.32 – $686.04 per year) effective 7/1/2019

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[1,7]	FY21 Projected[7]	FY22 Projected[7]	FY23 Projected[7]
Average Enrolled Members	123,132	125,488	125,861	128,308	130,874	133,491	136,161
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$814.8	$831.1	$847.7	$864.7	$882.0
3.2% Premium Increase 7/1/2019 (+2% FY21+)	-	-	-	*$26.6*	$43.9	$62.5	$82.2
Other Revenues[3]	$81.6	$92.1	$88.6	$99.3	$106.3	$113.8	$121.9
Total Operating Revenues	**$880.6**	**$903.0**	**$903.5**	**$957.0**	**$997.9**	**$1,041.0**	**$1,086.1**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)	$816.8	$853.9	$921.6	$985.6	$1,055.6	$1,130.5	$1,210.8
% Change Per Member	*1.8%*	*2.6%*	*7.4%*	*4.9%*	*5.0%*	*5.0%*	*5.0%*
FY20 Program Changes[4]				($9.6)	($10.1)	($10.6)	($11.1)
Excise Tax Liability[5]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($18.1)**	**($19.0)**	**($47.6)**	**($88.0)**	**($129.9)**
Balance Forward	$38.9	$102.7	$151.8	$133.7	$114.7	$67.1	($20.9)
Ending Balance	$102.7	$151.8	$133.7	$114.7	$67.1	($20.9)	($150.8)
- Less Claims Liability[6]	*$54.0*	*$58.9*	*$61.3*	*$64.9*	*$69.5*	*$75.1*	*$80.9*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*	*$24.3*	*$25.7*	*$27.5*	*$29.7*	*$31.8*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$48.1**	**$24.1**	**($29.9)**	**($125.7)**	**($263.5)**

Note: FY17 actual based on final June 2017 Fund Equity report; FY18 actual based on final June 2018 Fund Equity report; projected operating expenses based on experience through FY19 Q1; FY19 enrollment as of September 2018; reflects ESI FY17 Q4 restated claims; numbers in table may not add up due to rounding

[1] Includes approved design changes for site-of-care steerage for imaging/outpatient lab and COE services and proposed design changes for $0 statin coverage and preventive 3D mammography effective 7/1/2018 and implementation of SurgeryPlus COE effective 7/1/2019; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection).

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23.

[3] Includes Rx rebates, EGWP payments, other revenues; includes fees for participating non-State groups (assumed to increase proportionally with membership growth and health care trend).

[4] Includes estimated savings attributable to recommended changes eff. 7/1/2019: site-of-care steerage ($6.9m), Highmark infusion therapy ($2.0m), and Livongo ($0.7m); assumed to increase annually with trend

[5] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022. Threshold assumed to increase at 2% annually

[6] FY19 Claims Liability and FY19 Minimum Reserve levels updated with data through June 2018; future years assumed to increase with overall GHIP expense growth

[7] FY20-FY23 projections based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives); assumes no additional program changes in FY20; assumes 2% annual growth in GHIP membership.

FY20 monthly rates and employee/retiree contributions

Illustrative: 3.2% increase effective 7/1/2019

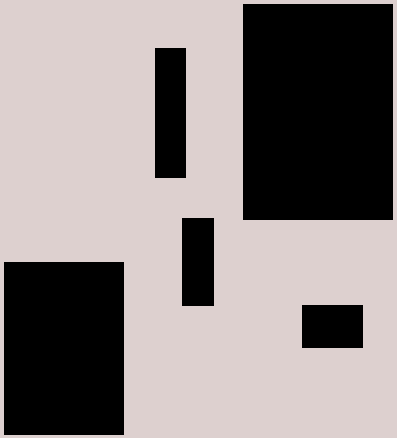
FY20 reflects employee contribution increases of $0.89 – $8.73 per month ($10.68 – $104.76 per year) and State subsidy increases of $21.36 – $57.17 per employee per month ($256.32 – $686.04 per year) effective 7/1/2019

	FY 2019			FY 2020 with 3.2% Increase			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$717.61	$28.73	$688.88	$0.89	$10.68	$21.36	$256.32
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,484.72	$59.36	$1,425.36	$1.84	$22.08	$44.20	$530.40
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,090.84	$43.61	$1,047.23	$1.35	$16.20	$32.47	$389.64
Family	$1,798.42	$71.92	$1,726.50	$1,855.97	$74.22	$1,781.75	$2.30	$27.60	$55.25	$663.00
CDH Gold										
Employee	$719.68	$35.98	$683.70	$742.71	$37.13	$705.58	$1.15	$13.80	$21.88	$262.56
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,539.97	$76.97	$1,463.00	$2.39	$28.68	$45.36	$544.32
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,134.75	$56.72	$1,078.03	$1.76	$21.12	$33.43	$401.16
Family	$1,895.74	$94.78	$1,800.96	$1,956.40	$97.81	$1,858.59	$3.03	$36.36	$57.63	$691.56
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$749.17	$48.67	$700.50	$1.51	$18.12	$21.72	$260.64
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,579.56	$102.68	$1,476.88	$3.18	$38.16	$45.80	$549.60
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,146.06	$74.49	$1,071.57	$2.31	$27.72	$33.23	$398.76
Family	$1,909.82	$124.12	$1,785.70	$1,970.93	$128.09	$1,842.84	$3.97	$47.64	$57.14	$685.68
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$819.26	$108.55	$710.71	$3.37	$40.44	$22.03	$264.36
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,700.05	$225.24	$1,474.81	$6.98	$83.76	$45.73	$548.76
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,262.61	$167.27	$1,095.34	$5.19	$62.28	$33.96	$407.52
Family	$2,059.40	$272.86	$1,786.54	$2,125.30	$281.59	$1,843.71	$8.73	$104.76	$57.17	$686.04

Next steps

- Further discussion of FY20 program opportunities, as needed
- Willis Towers Watson to present updated long term projections based on claims data through Q2 FY19 at February 11th meeting
- SEBC to vote on FY20 program changes and premium rate increases at the ***February 11th meeting***

Appendix



= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – basic and high tech imaging services

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** Non-preferred basic imaging increases +$5/visit, high tech increases +$10/visit	0.23%	$0.4m	$0.3m
Highmark		0.10%	$0.4m	$0.3m
	Total Cost Avoidance Opportunity – Option 1:		**$0.8m**	**$0.5m**
Aetna	**Option 2:** Non-preferred basic imaging increases +$15/visit, high tech increases +$15/visit	0.43%	$0.7m	$0.5m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 2:		**$1.6m**	**$1.1m**
Aetna	**Option 3:** Non-preferred basic imaging increases +$15/visit, high tech increases +$25/visit	0.49%	$0.8m	$0.5m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 3:		**$1.7m**	**$1.1m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*1.27%*	$2.1m	$1.4m
Highmark		*1.40%*	$6.1m	$4.0m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$8.3m**	**$5.5m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for basic and high-tech imaging services only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – outpatient lab services

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** Non-preferred lab copay increases +$10/visit	0.19%	$0.3m	$0.2m
Highmark		0.30%	$1.3m	$0.9m
	Total Cost Avoidance Opportunity – Option 1:		**$1.6m**	**$1.1m**
Aetna	**Option 2:** Non-preferred lab copay increases +$20/visit	0.36%	$0.6m	$0.4m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 2:		**$2.4m**	**$1.6m**
Aetna	**Option 3:** Non-preferred lab copay increases +$30/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 3:		**$2.6m**	**$1.7m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*0.62%*	$1.0m	$0.7m
Highmark		*1.10%*	$4.8m	$3.2m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$5.9m**	**$3.9m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for outpatient lab services only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.
Preferred labs for both Aetna and Highmark: Quest and Labcorp.

= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – emergency / urgent care

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** ER copay increases +$25/visit	0.30%	$0.5m	$0.3m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 1:		**$1.4m**	**$0.9m**
Aetna	**Option 2:** ER copay increases +$50/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 2:		**$2.6m**	**$1.7m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*1.61%*	$2.7m	$1.8m
Highmark		*0.60%*	$2.6m	$1.7m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$5.3m**	**$3.5m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for emergency / urgent care only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

Site-of-care steerage opportunities for FY20

Aetna and Highmark recommendations for potential plan design changes

Aetna

- For imaging and lab services, would not recommend any copays greater than option 3
- For emergency / urgent care, would not recommend any copays greater than option 2

Highmark

- Recommendations for designs are mostly covered in the scenarios outlined by WTW
- Regarding imaging, would not recommend $0 for any non-routine service, so consider a nominal copay (especially high tech imaging)
- For lab services, Options 2-3 seem high for non-preferred labs, in light of average total allowed cost for those
- Minimum ER copays for fully-insured customers is $150/visit (consistent with FY19 current design)

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – imaging services

Service ***For PPO and HMO plans only***	**FY19 Current**	**FY20 Design Options**			
		Option 1	**Option 2**	**Option 3**	**Max Opportunity *(illustrative)***
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $40 copay	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $50 copay	n/a
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $60 copay	▪ $0 copay ▪ $65 copay	▪ $0 copay ▪ $75 copay	
Estimated number and percent of services steered toward preferred site of care		▪ Basic: 1,515 (3%) ▪ High Tech: 515 (3%)	▪ Basic: 2,781 (5%) ▪ High Tech: 707 (4%)	▪ Basic: 2,781 (5%) ▪ High Tech: 1,052 (6%)	▪ Basic: 56,130 (100%) ▪ High Tech: 18,407 (100%)
Estimated cost avoidance opportunity		$0.8m annual claim savings ($0.5m to General Fund)	$1.6m annual claim savings ($1.1m to General Fund)	$1.7m annual claim savings ($1.1m to General Fund)	$8.3m annual claim savings ($5.5m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copy differential rather than changes in member behavior.

Highlights potential FY20 design change.

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – outpatient lab services

Service *For PPO and HMO plans only*	FY19 Current	FY20 Design Options			
		Option 1	Option 2	Option 3	Max Opportunity *(illustrative)*
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $30 copay	▪ $10 copay ▪ $40 copay	▪ $10 copay ▪ $50 copay	n/a
Estimated number and percent of services steered toward preferred site of care		2,642 (1%)	5,212 (2%)	7,715 (4%)	216,206 (100%)
Estimated cost avoidance opportunity		$1.6m annual claim savings ($1.1m to General Fund)	$2.4m annual claim savings ($1.6m to General Fund)	$2.6m annual claim savings ($1.7m to General Fund)	$5.9m annual claim savings ($3.9m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.
Preferred labs for both Aetna and Highmark: Quest and Labcorp.
Highlights potential FY20 design change.

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – emergency / urgent care

Service ***For PPO and HMO plans only***	**FY19 Current**	**FY20 Design Options**		
		Option 1	**Option 2**	**Max Opportunity *(illustrative)***
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $175 copay	▪ $15/$20 copay ▪ $200 copay	n/a
Estimated number and percent of services steered toward preferred site of care		288 (2%)	454 (2%)	18,976 (100%)
Estimated cost avoidance opportunity		$1.4m annual claim savings ($0.9m to General Fund)	$2.6m annual claim savings ($1.7m to General Fund)	$5.3m annual claim savings ($3.5m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

Highlights potential FY20 design change.

Presented at 12/4 financial subcommittee meeting

Reserve and claim liability discussion

Current claim liability methodology

Claims Liability Targets by Quarter

12/31/16	3/31/17	6/30/17	9/30/17	12/31/17	3/31/18	6/30/18
$54.3m	$54.3m	$56.5m	$59.5m	$58.9m	$58.9m	$61.3m

- Recommended Claim Liability target is based on estimated incurred but not paid ("IBNP") liability as of 6/30/2018
  - Medical Claim Liability (Highmark and Aetna): $52.8M
  - Pharmacy Claim Liability (ESI Commercial and EGWP): $8.5M
- IBNP liability is based on paid claims for the period 7/1/2017 – 6/30/2018 and lag factors developed by Willis Towers Watson as of 6/30/2018
  - Lag factors represent the average period of time between when a claim is incurred and then paid by the State, and were developed separately for Aetna, Highmark, and ESI based on data provided by each vendor
  - Lag factors are reviewed and updated (if needed) annually
  - Claim Liability target is updated quarterly based on most recent 12 months of paid claims data
- IBNP liability has been increasing over time, driven by an increase in paid claim levels and an increase in Aetna's lag factor

Presented at 12/4 financial subcommittee meeting

Reserve and claim liability discussion

Current minimum reserve methodology

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$833.0M	
70% Confidence Interval	$821.4M	$844.5M
90% Confidence Interval	$814.6M	$851.3M
95% Confidence Interval	$811.1M	$854.9M
97% Confidence Interval	$808.8M	$857.3M

At the 97% confidence interval level, the upper bound is $24.3M higher than the projected budget

- During March 6, 2017 meeting, SEBC approved a motion to set minimum reserve based on upper bound of 97% confidence interval of Willis Towers Watson health care trend variability tool, set annually based on final fiscal year budget
  - Confidence intervals represent the probability that the budget estimate will fall between an upper and lower bound of a health care claims distribution

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

Reserve and claim liability discussion

Minimum reserve methodology – ***Alternative 1***

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$833.0M	
70% Confidence Interval	$821.4M	$844.5M
90% Confidence Interval	$814.6M	$851.3M
95% Confidence Interval	$811.1M	$854.9M
97% Confidence Interval	$808.8M	$857.3M
98.5% Confidence Interval	$805.8M	$860.1M

At the 97% confidence interval level, the upper bound is $24.3M higher than the projected budget

$27.1M at 98.5% confidence interval

- The above exhibit reflects reforecasted FY19 projected costs based on data through FY19 Q1
- Increasing the confidence interval from 97% to 98.5% increases the FY19 minimum reserve from $24.3M to $27.1M

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

Presented at 12/4 financial subcommittee meeting

Reserve and claim liability discussion

Minimum reserve methodology – ***Alternative 2***

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value	$833.0M	
Expected Value plus 1% population risk load	$840.9M	
70% Confidence Interval	$829.4M	$852.5M
90% Confidence Interval	$822.6M	$859.3M
95% Confidence Interval	$819.0M	$862.8M
97% Confidence Interval	$816.7M	$865.1M
98.5% Confidence Interval	$813.8M	$868.1M

At the 97% confidence interval level, the upper bound with load is $32.1M higher than the projected budget of $833.0M

$35.1M at 98.5% confidence interval

- The above exhibit reflects reforecasted FY19 projected costs based on data through FY19 Q1, plus additional 1% load for potential population risk volatility not captured by the variability tool
- Increasing the confidence interval from 97% to 98.5% and including a 1% population risk load increases the FY19 minimum reserve from $24.3M to $35.1M

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market, which could exceed the 1% population risk load.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

Presented at 10/25 financial subcommittee meeting

GHIP FY12-FY18 Historical Lookback

FY12-FY18 gross claims and revenue per member

Plan Year	Gross Claims[1]		National Average Trend[2]	Premium Contributions[3]		Members	
	Per Member Per Year	Annual Increase/ (Decrease)		Per Member Per Year	Annual Increase/ (Decrease)	Average	Annual Increase/ (Decrease)
FY12	$5,009	4%	7%	$5,088	-1%	115,357	4%
FY13	$5,056	1%	6%	$4,979	-2%	117,421	2%
FY14	$5,488	9%	6%	$5,120	3%	119,225	2%
FY15	$5,980	9%	5%	$5,148	1%	121,167	2%
FY16	$6,190	4%	6%	$6,021	17%	122,238	1%
FY17	$6,331	2%	6%	$6,512	8%	122,693	0%
FY18	$6,533	3%	6%	$6,500	0%	124,754	2%

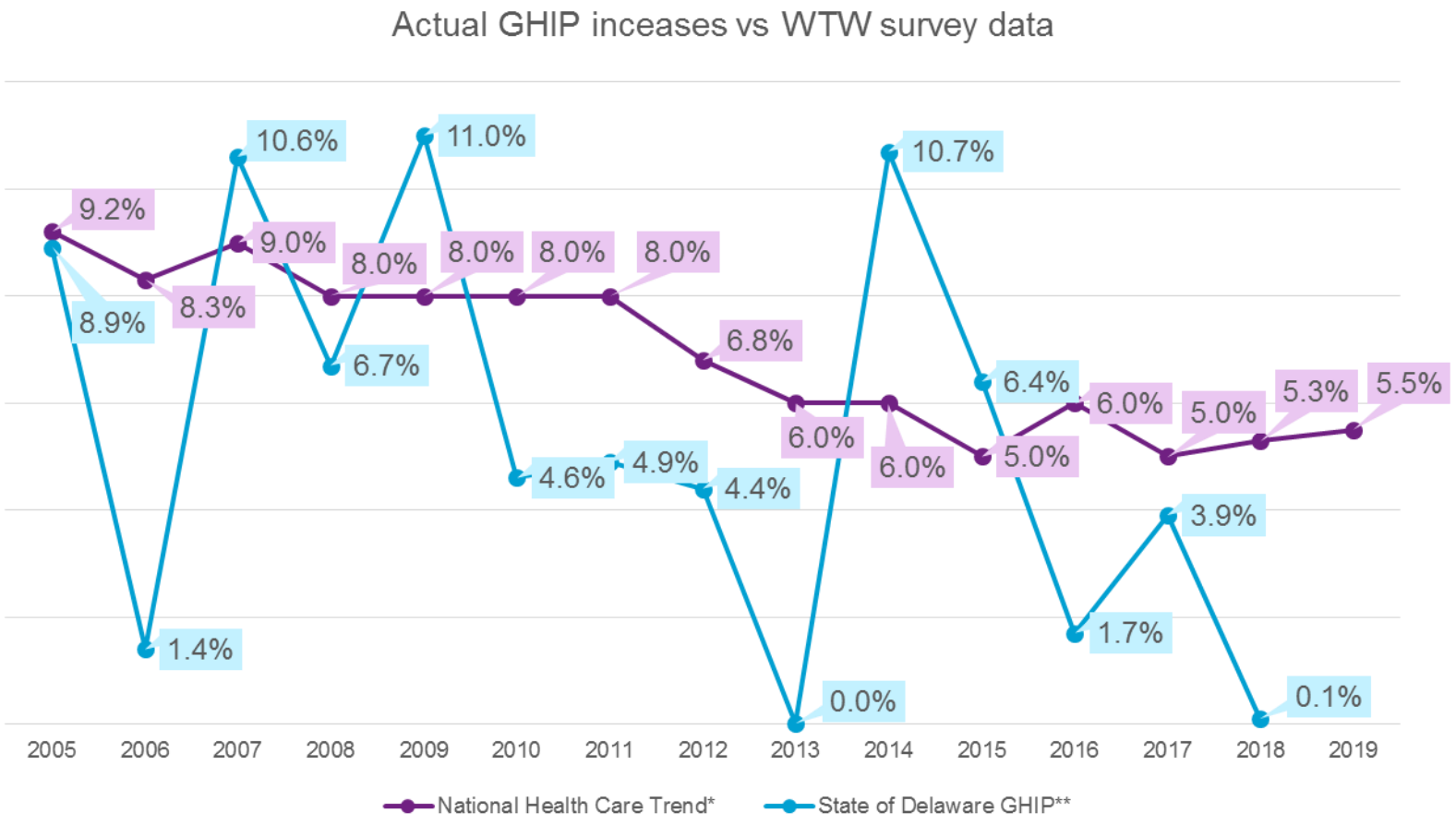
Source: GHIP Fund Equity FY12 – FY18

[1]Includes total medical and prescription drug claims for actives, pre-65 retirees and Medicare retirees; excludes claim offsets (e.g., Rx rebates and EGWP revenues).
[2]National Benchmark Source: Willis Towers Watson Emerging Trends survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs.
[3]Includes State and employee share of health fund premiums for actives and retirees. Excludes other revenue sources and employee out-of-pocket costs.

Presented at 10/25 financial subcommittee meeting

Historical GHIP cost increases

Actual GHIP increases vs. WTW survey data



*National Benchmark Source: Willis Towers Watson Best Practices in Healthcare survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs. 2018 and 2019 benchmark data is projected.
**2007-2015 GHIP Trend data estimated based on Segal's State_of_Delaware_-_Trend_History_thru_Q2_FY16 030416.pdf
**2016-18 GHIP trend based on WTW financial reporting for corresponding fiscal year (includes net paid claims and fees) on a per employee per year basis

Presented at 10/25 financial subcommittee meeting (updated 12/4 meeting)

Health care cost trend overview

Projected market data for 2019 – active/pre-65 retiree

Source	Medical/Rx		Medical Only	Rx Only	
	Gross[1]	Net[2]	Gross[1]	Gross[1]	Net[2]
Willis Towers Watson	5.5%	5.0%			
Aon	6.5%	4.1%			
Mercer	5.3%	4.1%			
PricewaterhouseCoopers	6.0%				
Segal			7.1%[3]	7.5%	
Aetna			11.0%[4]		
Highmark DE			4.5%[5]		
Express Scripts					2.4%[6]
Average	**5.8%**	**4.4%**	**7.5%**	**7.5%**	**2.4%**

[1] Before plan changes
[2] After plan changes
[3] Trend reflects open access PPO/POS plans
[4] Trend reflects Delaware book of business
[5] Trend reflects active population only
[6] Net of plan changes, rebates, and contract pricing changes